APPLICATION TEMPLATE FOR HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) §1115 DEMONSTRATION PROPOSAL

The State of Montana, Department of Public Health and Human Services, proposes to amend the existing section 1115 Basic Medicaid Waiver for Able-Bodied Adults with "A Proposal to Provide Health Care Services to Uninsured Low-Income Montanans Through an 1115 Medicaid Waiver," which will increase the number of individuals with health insurance coverage.

I. GENERAL DESCRIPTION OF PROGRAM

The amended waiver, which is scheduled to begin on July 1, 2007, will provide health care coverage to an additional 5,000 residents of the State of Montana with incomes at or below 200 percent of the Federal Poverty Level. The increased coverage will be funded by savings from the existing 1115 Basic Medicaid Waiver for Able-Bodied Adults and state funds currently used to provide mental health benefits for uninsured adults.

II. DEFINITIONS

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments).

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

☑ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

☑ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort will apply.

☑ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

☑ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

☑ HIFA demonstrations covering childless adults can only receive the Medicaid match rate. As a result of the passage of the Deficit Reduction Act (DRA), states can no longer receive the SCHIP enhanced match rate for childless adults for HIFA applications submitted on, or after, October 1, 2005.

☑ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability, or premium and cost sharing contributions made by or on behalf of program participants.

☑ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

IV. STATE SPECIFIC ELEMENTS

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is 200 percent FPL.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations (as specified in Title XIX)

- ☑ Section 1931 Families (Limited to adults eligible for the 1115 Basic Medicaid Waiver for Able-Bodied Adults)
- ❑ Blind and Disabled
- ❑ Aged
- ❑ Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

- ❑ Children and pregnant women covered in Medicaid above the mandatory level
- ❑ Parents or caretaker relatives covered under Medicaid
- ❑ Children covered under SCHIP
- ❑ Parents or caretaker relatives covered under SCHIP
- ❑ Other (please specify)

Medically Needy

- ❑ TANF Related
- ❑ Blind and Disabled
- ❑ Aged

- ❑ *Title XXI children (Separate SCHIP Program)*

- ❑ *Title XXI parents or caretaker relatives (Separate SCHIP Program)*

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the

optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.

Populations that can be covered under a Medicaid or SCHIP State Plan

☑ Children above the income level specified in the State Plan. This category will include children from 0 percent FPL through 150 percent FPL.

❑ Pregnant women above the income level specified in the State Plan. This category will include individuals from ___ percent FPL through ___ percent FPL.

☑ Parents above the current level specified in the State Plan. This category will include individuals from 0 percent FPL through 200 percent FPL.

☑ Other:
(1) Uninsured former foster care youth ages 18 through 20 with severe emotional disturbance with incomes from 0 percent FPL through 150 percent FPL.
(2) Uninsured working adults 19 to 65 with children under age 21 and incomes from 0 percent FPL through 200 percent FPL.
(3) Uninsured working youth ages 18 through 20 with incomes from 0 percent FPL through 200 percent FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

❑ Pregnant Women in SCHIP (This category will include individuals from ___ percent FPL through ___ percent FPL.)

❑ Other. Please specify:

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the HIFA demonstration.

❑ Pregnant Women in SCHIP (This category will include individuals from ___ percent FPL through ___ percent FPL.)

☑ Other. Please specify:
(1) People eligible for the Mental Health Services Plan who are uninsured.

(2) People eligible for the Montana Comprehensive Health Association Premium Assistance Program with incomes less than or equal to 150 percent FPL.

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

❑ No ☑ Yes If Yes, Number of participants or dollar limit of demonstration (express dollar limit in terms of total computable program costs). $47,303,383 in state funds over the 5 year demonstration period.

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased in.

❑ The HIFA demonstration will be implemented at once.
☑ The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline): Eligible Mental Health Services Plan beneficiaries will begin their physical health benefit on July 1, 2007. Montana plans to add 100 SED youth per year for fiscal years 2008, 2009, and 2010, until a total of 300 youth are enrolled. Montana does not anticipate that other eligibility groups will have maximum enrollment on July 1, 2007, but rather the beneficiaries will be added over a period of several months, up to one year.

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

- ❑ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

- ☑ Other: A reduced benefit of optional services specified in the existing Basic Medicaid 1115 Waiver for Able-Bodied Adults.

2. Optional populations included in the existing Medicaid State Plan

- ❑ The same coverage provided under the State's approved Medicaid State Plan.
- ❑ The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State.

- ❑ The standard Blue Cross Blue Shield preferred provider option service benefit pan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- ❑ A health benefits coverage plan that is offered and generally available to State employees.
- ❑ A benefit package that is actuarially equivalent to one of those listed above.
- ❑ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State Plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

- ❑ The same coverage provided under the State's approved Medicaid State Plan.
- ❑ The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State.
- ❑ The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- ❑ A health benefits coverage plan that is offered and generally available to State employees
- ❑ A benefit package that is actuarially equivalent to one of those listed above
- ❑ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

- ❑ The same coverage provided under the State's approved Medicaid State Plan.
- ❑ The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State.
- ❑ The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP)).
- ❑ A health benefits coverage plan that is offered and generally available to State employees
- ☑ A benefit package that is actuarially equivalent to one of those listed above—optional uninsured children group.

☑ Secretary approved coverage. (The proposed benefit packages are described in Attachment D.) Optional uninsured working parents of children with Medicaid group, optional former SED foster youth group, optional uninsured working adults with children, and optional uninsured working youth ages 18 through 20.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations—States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included:

- ❑ Inpatient
- ❑ Outpatient
- ❑ Physician's surgical and medical services
- ❑ Laboratory and x-ray services
- ❑ Pharmacy
- ☑ Other (please specify). Please include a description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations. Applies to Mental Health Services Plan expansion group and Montana Comprehensive Health Association expansion group.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private Health Insurance Coverage	Group Health Plan Coverage	Other (specify)
Mandatory	✔				
Optional—Existing					
Optional—Expansion	✔		✔	✔	✔ FFS
Title XXI—Medicaid Expansion					
Title XXI—Separate SCHIP					
Existing Section 1115 Expansion					
New HIFA Expansion	✔		✔	✔	✔ For SED: CHIP-like benefit, enhanced mental health, transition life skills, NurseFirst

Please include a detailed description of any private health insurance coverage options as Attachment D in your proposal.

Detailed descriptions of private health insurance coverage options are included in Attachment D.

G. Private Health Insurance Coverage Options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

☑ As part of the demonstration, the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

- ❑ The same coverage provided under the State's approved Medicaid plan.
- ❑ The same coverage provided under the State's approved SCHIP plan.
- ❑ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.
- ❑ The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP)).
- ❑ A health benefits coverage plan that is offered and generally available to State employees.
- ❑ A benefit package that is actuarially equivalent to one of those listed above (please specify).
- ❑ Secretary-Approved coverage.
- ☑ Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)

☑ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

☑ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory	✔ Existing 1115 waiver		
Optional—Existing (Children)			
Optional—Existing (Adults)			
Optional—Expansion (Children)		✔ Uninsured children	
Optional—Expansion (Adults)			
Title XXI—Medicaid Expansion			
Title XXI—Separate SCHIP			
Existing Section 1115 Expansion			
New HIFA Expansion		✔ Former SED youth	✔ Other: Varies, no limit MHSP, MCHA, Uninsured parents, adults w/children, working youths 18 through 20

Cost-sharing for children
Only those cost-sharing amounts that can be attributed directly to the child (i.e. copayments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as "child cost-sharing" for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted in the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

No children will be covered as part of a family under Montana's waiver proposal. The state will purchase insurance for each child covered under the waiver.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. ACCOUNTABILITY AND MONITORING

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State as of 2003 for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project: 30 percent

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project:

Private Health Insurance Coverage Under a Group Health Plan or Other Private Health Insurance Coverage: 31 percent, including 26 percent under group plans and 5 percent under individual plans

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance _____

SCHIP (please separately identify any premium assistance) _____

18 percent were covered by Medicaid or SCHIP. In our 2003 State Household Survey Report, Medicaid and SCHIP were combined and reported together.

Neither Medicaid nor SCHIP have a section 1906 or section 1115 premium assistance component

Medicare: 21 percent

Other Insurance _____

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

- ❑ The Current Population Survey
- ❑ Other National Survey (please specify)
- ☑ State Survey (please specify) State Health Planning Grant Household Survey, 2003.
- ❑ Administrative records (please specify)
- ❑ Other (please specify)

Adjustments were made to the Current Population Survey or another national survey.

❑ Yes ☑ No

If yes, a description of the adjustments must be included in Attachment F.

A State Survey was used.

☑ Yes ❑ No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F. If a State Survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data. Additional details on the State Survey and future efforts are described in Attachment F.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

Montana's uninsured rate is 19 percent (2003 State Health Planning Grant Household Survey). Through the HIFA waiver, 5,000 people will receive health care coverage. Montana expects the uninsurance rate to decrease by 1 percent.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

☑ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage. States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

❑ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov.) The Medical Care Consumer Price Index will only be

offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not be used to submit detailed historical data.

☑ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be $296,302,761 over its five year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable.)

Title XIX:
☑ Statewideness 1902(a)(1)
To enable the State to phase in the operation of the demonstration.

☑ Amount, Duration, and Scope (1902(a)(10)(B)
To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e. amount, duration, and scope) may vary by individual based on eligibility category.

☑ Freedom of Choice 1902(1)(23)
To enable the State to restrict the choice of provider.

Title XXI:
❑ Benefit Package Requirements 2103
To permit the State to offer a benefit package that does not meet the requirements of section 2103.

❑ Cost Sharing Requirements 2103(e)
To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

☑ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

❑ Expenditures related to providing ___ months of guaranteed eligibility to demonstration participants.

☑ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:
❑ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

❑ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification and Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

❑ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage. No individuals above 200 percent FPL will be covered by the waiver.

☑ Attachment B: Detailed description of expansion populations included in the demonstration.

☑ Attachment C: Benefit package description.

☑ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

☑ Attachment E: Detailed discussion of cost sharing limits.

☑ Attachment F: Additional detail regarding measuring progress toward reducing the rate of insurance.

☑ Attachment G: Budget worksheets.

❑ Attachment H: Additional waivers or expenditure authority request and justification. No additional expenditure authority or waivers are requested at this time.

IX. SIGNATURE

July 21, 2006
Date

John Chappuis, Montana State Medicaid Director
Name of Authorizing State Official (Typed)

_____
Signature of Authorizing State Official

ATTACHMENT B: DETAILED DESCRIPTION OF EXPANSION POPULATIONS

1. Mental Health Services Plan: Expansion Population

Eligibility Criteria
MHSP currently provides mental health services and pharmacy benefits to approximately 2,200 people per month who have a Severe Disabling Mental Illness but are not eligible for Medicaid. The number of people enrolled in MHSP is limited by current legislative appropriations and not by a cap on the number of slots created by DPHHS. MHSP beneficiaries are not eligible for Medicaid services because they do not meet the income and resource eligibility requirements. The income limit for MHSP is 150 percent FPL and there is no asset or resource test.

Waiver Participation Criteria
All MHSP eligible beneficiaries with no other health care coverage will participate in the physical health benefit unless they opt out of the benefit. Approximately one-third of MHSP beneficiaries will not participate in the proposed waiver program because they currently have private health insurance or they have health care coverage under Medicare. Under the Federal waiver guidelines, the state cannot obtain federal matching dollars for the health care services received by insured beneficiaries. Therefore, the State will continue to provide existing MHSP mental health services and prescription drugs to currently insured members using state dollars.

Eligible beneficiaries will receive education and assistance in choosing the most appropriate coverage option for their needs. DPHHS estimates that up to 1,500 MHSP clients will be eligible to participate in this waiver proposal.

2. Montana Comprehensive Health Association Premium Assistance Program: Expansion Population

Eligibility Criteria
The Montana Comprehensive Health Association (MCHA) Premium Assistance Program is a source of health insurance for people who have serious medical conditions that cause them to be denied coverage by private health insurers and whose incomes are less than or equal to 150 percent FPL.

A person may be eligible for MCHA if he or she:

- is a resident of the state of Montana and has been for at least 30 days; and,
- has been rejected or offered a restrictive rider by two insurers within the last six months or has one of the listed specified illnesses (available on the MCHA website at www.mthealth.org); and
- is not eligible for any other health insurance coverage; or, has comparable coverage but is paying or has received a notice of a premium rate that is more than 150% of the average premium rate used to calculate MCHA premium rates.

The MCHA Premium Assistance Program is open on a limited basis. Enrollment is on a first-come, first served basis. When available spaces are filled, the program will be closed to new enrollment.

Waiver Participation Criteria
DPHHS estimates up to 260 MCHA clients will be eligible to participate in this waiver proposal. Approximately ten percent of MCHA clients will not be able to participate because they have health care coverage under Medicare. Therefore, the State will continue to provide existing benefits to Medicare beneficiaries using state dollars.

1. Existing Waiver:
Montana Basic Medicaid for Able-Bodied Adults, Waiver Number 11-W-00181/8

On November 20, 1995, the State of Montana's welfare reform demonstration, entitled "Families Achieving Independence in Montana" (FAIM), was approved under the authority of Section 1115 of the Social Security Act (the Act). The demonstration was effective from February 1, 1996, through January 31, 2004. According to the State Medicaid Directors' Letter dated February 5, 1997, the State could not extend the Title XIX component of FAIM beyond the specified eight-year period. Any continuation of these Medicaid waivers would be subject to new terms and conditions, including a budget neutrality test and an evaluation.

"Basic Medicaid" was a component of the program, whereby parents and/or caretaker relatives of dependent children, as described in Sections 1925 and 1931 of the Act, who are ages 21 to 64 and neither pregnant nor disabled, received a limited package of Medicaid services. The State was able to reduce optional services to able-bodied adults. Montana was aware that optional services could have been eliminated for all Medicaid recipients via a state plan amendment. However, the State recognized that the elimination of optional services for all individuals could have a negative impact on those who were medically fragile or at risk, and a negative impact on the State's budget, as individuals would seek care in more expensive environments. Under this demonstration, parents and/or caretaker relatives of dependent children, as described in sections 1925 and 1931 of the Act, who are aged 21 to 64 and neither pregnant nor disabled receive a limited package of Medicaid services. Approval of this demonstration was controversial, as it represented the first Medicaid-only Section 1115 demonstration designed solely to reduce optional services to a mandatory population.

Amendment
Amendment Number 1 was submitted on May 20, 2004, to correct a technical error contained in the budget neutrality section (Attachment C) of the Special Terms and Conditions that were approved on January 29, 2004. This change adds one month to the trending necessary to span the base year to the beginning of the demonstration years. Originally, 18 months of trend rate was used to span the base year to DY1, but 19 months of trend rate should have been used. This amendment is effective retroactive to February 1, 2004, the beginning of the demonstration.

Components of the Waiver:
Eligibility: The demonstration covers able-bodied adults, parents and/or caretaker relatives of dependent children, as described in Sections 1925 and 1931 of the Act, who are aged 21 to 64 and neither pregnant nor disabled.

Enrollment: As of April 1, 2006, Title XIX funded state plan eligibles—9,648.

Benefits: A limited package of Medicaid services is offered to the eligible population. Medical services such as audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, person care services, and hearing aids are excluded to align coverage with that of a typical work-related insurance program. However, the State provides coverage for emergency dental situations, medical conditions of the eye, certain medical supplies such as diabetic supplies and oxygen, and services essential for employment.

Cost Sharing: Individuals subject to the demonstration who are tribal members are not charged cost sharing when receiving services from the Indian Health Services.

The amount of cost sharing for individuals in the demonstration is the same as the amount specified in the State Plan for Montana. Affected providers or services exempt from cost sharing include: emergency services, hospice, non-emergency transportation, independent laboratory and x-ray services, and family planning.

Cost Sharing			
Enrollment Fee	**Copayments**	**Coinsurance**	**Maximum**
None	$1-$5 prescription $1-$5 outpatient office visit	$100 inpatient hospital stay	$25 monthly prescription maximum

Delivery System: The delivery system for these able-bodied adults is through fee-for-service.

Funding Projections: Title XIX funding for the 5 year demonstration period is $151 million.

2. CHIP-Like Health Care Benefit—Public Health Care Coverage for Uninsured Low-Income Children

CHIP is a low-cost health insurance plan that provides health insurance to eligible Montana children up to age 19. A child qualifies for CHIP based on family income and family size. There is no asset test and no income documentation required at the time of application.

Montana CHIP is currently the main source of critically needed health care coverage for approximately 13,113 otherwise uninsured Montana children (as of July 2006) who are ineligible for Medicaid but have family incomes less than or equal to 150 percent FPL. Because the enrollment in CHIP is limited by the amount of state funds available, eligible children may be required to wait until there are openings or additional resources are allocated to the program. The Montana State Planning Grant report indicates there may be up to 22,000 uninsured Montana children who are eligible for CHIP or Medicaid but not enrolled in either program. Of this number, approximately 15,000 uninsured children are eligible for CHIP but not enrolled. While there is a great deal of interest in increasing the number of children enrolled in CHIP, there are two issues that must be addressed before expanding the program.

A. *State Match*: In order to increase the number of children enrolled in CHIP, the state must pay approximately 20 percent of the total cost. Finding a source for state matching funds necessary to expand any state program, even one as popular as CHIP, is always difficult. Governor Brian Schweitzer identified additional funding for CHIP

as a priority during the 2005 Montana Legislature. Using new revenue resources generated under the tobacco tax initiative (I-149), the Legislature added funds to expand CHIP enrollment from 10,900 to 13,900 children. In addition, the Legislature passed House Bill 552, effective July 1, 2006, that will change the Medicaid asset test for children. This legislation will ultimately result in approximately 2,975 children moving from CHIP to Medicaid, freeing slots for coverage under CHIP for children with assets greater than $15,000.

B. *Federal Grant Funds*: DPHHS believes the availability of additional federal grant funds is uncertain. In addition to state matching funds, expansion of CHIP requires that there be sufficient federal CHIP grant authority to support the expansion. Although Montana currently has a balance of over $20 million in federal CHIP grant funding, it is important to note that the federal share of projected CHIP expenditures in FY 2005 exceeds the amount of that year's annual federal grant award by about $1 million. A surplus in carry-over funds from the grants for previous years will be sufficient to support the current level of CHIP spending for the foreseeable future. However, without an increase in the annual grant award, or the reallocation of a significant amount of unused federal CHIP funding from other states, the potential for a large expansion of CHIP may be limited. While a future increase in the size of the federal grant and/or reallocation of funding from other states is likely, the magnitude and timing of additional funding is less than certain. With the increases in state matching funds authorized by the 2005 Legislature, Montana has increased the demand on the CHIP grant authority and the demand on the reallocation funding of unused federal CHIP funds from other states. Montana is expecting Congress to grant additional CHIP authority or reallocation funding for CHIP to cover the expansion as authorized by the Legislature. Therefore, based on this analysis Montana does not foresee the availability of unused federal CHIP authority as a mechanism to meet the cost neutrality requirements of the waiver. In addition, the budget neutrality requirements do not allow the use of unused reallocation funding under CHIP to meet these requirements of the waiver.

CHIP Eligibility Requirements

- Uninsured children up to age 19
- Montana residents and US citizens or qualified aliens
- Not currently insured, not covered by insurance in the past three months (some exceptions apply)
- Parents cannot be employed by the State of Montana
- Children are not eligible for Medicaid
- Household meets income guidelines at 150 percent FPL for family size

If CHIP enrollment exceeds the maximum enrollment for available funds, eligible children are placed on a waiting list. As enrolled children become disenrolled (if they reach the age of 19, receive Medicaid or other health care coverage, move from Montana, or do not qualify upon renewal), available spaces are filled by children on the waiting list on a first-come, first-served basis.

CHIP benefits

Covered Services	Copayments	Limitations/Other Information
Physician and advance practice registered nurses	$3 physician visit	
Inpatient and outpatient hospital services	$25 inpatient hospital visit $5 outpatient hospital visit $5 emergency room visit	
Routine sports and employment physicals		
General anesthesia services		
Surgical services		
Clinic and ambulatory health care services		
Prescription drugs	$3 generic prescription drug $5 brand name prescription drug	
Laboratory and radiological services		
Inpatient, outpatient, and residential mental health services		Maximum 20 outpatient visits, 21 inpatient days per benefit year
Inpatient, outpatient, and residential substance abuse treatment services		
Dental services	None	$425 services per benefit year
Vision exams and eyeglasses		Limit 1 pair eyeglasses per 365 days
Hearing exams		
Well-baby and well-child care	None	Includes age appropriate immunizations

CHIP requires no copayments for Native American children and children living in households with incomes at 100 percent of the Federal Poverty Level or less. Maximum copayments per family per benefit year (October 1 through September 30) are $215. All children enrolled in CHIP have a $1 million lifetime maximum.

3. Enhanced CHIP-Like Benefit—Public Health Care Coverage for Uninsured Former SED Foster Youth Ages 18 Through 20

The Department's HIFA waiver proposal includes a plan to use a portion of the state's savings from securing Medicaid funding for the Mental Health Services Plan as match to provide high-risk uninsured youth who have Serious Emotional Disturbance (SED) with a Medicaid-funded physical health care benefit and a set of therapeutic and support services designed to assist them in making a successful transition to adulthood. The plan calls for serving up to 300 youth with SED at a projected annual total cost of $2.3 million.

Montana provides Medicaid funded mental and physical health care to 6,000 children who have SED and are under age 18. The Department's Child and Family Services Division (CFSD) is legal guardian for some Medicaid eligible SED children, many of whom reside in licensed foster care homes. A smaller group of low-income SED children remain with their natural families,

receiving Medicaid-funded treatment and therapeutic family services. Finally, a small percentage of children with the most serious emotional and behavioral problems are served in higher-cost 24-hour residential treatment facilities or psychiatric hospitals, with funding from Medicaid.

One of the significant challenges associated with serving SED children in general, and children who reside in 24-hour treatment program in particular, is assisting them in making a smooth transition to adulthood. Facing the demands and challenges of becoming an adult is made more difficult by the fact that they no longer qualify for Medicaid as children when they turn 18 and may not qualify for Medicaid as an adult because they do not meet the Social Security Administration's definition of disabled. Some are ineligible for state-funded adult mental health services under the Mental Health Services Plan because their condition does not meet the state's definition of Severe Disabling Mental Illness, which has greater clinical acuity criteria than SED.

While many SED children do make a relatively smooth transition to adulthood, some do not. For these young people the expectation that they cope with their existing emotional problems without the benefit of the services and supports they counted on as children, and at the same time deal successfully with the additional emotional and practical challenges and expectations that come with being a young adult, is an unrealistic expectation.

Surveys of former foster care youth indicate that 22 percent become homeless after foster care, 33 percent earn below the federal poverty limit, 50 percent have used illegal drugs, 48 percent have not graduated from high school at the time of discharge from services, and 25 percent are involved in the legal system (Child Trends 2003). Their failure to successfully adapt often results in chronic unemployment, substance abuse, frequent contact with law enforcement agencies and, all too often, eventual incarceration. For some, the loss of mental health services exacerbates their emotional problems to the point where they meet the federal and/or state adult mental disability criteria and are again eligible for publicly funded mental health services. Unfortunately, by the time they are determined to be Medicaid eligible as adults, the nature and degree of their emotional problems are often more serious. In addition to the obvious negative impact on their mental health, losing Medicaid eligibility at age eighteen typically means that these young men and women no longer have access to public or private physical health care benefits and they join the ranks of the uninsured.

Eligibility for Enhanced Benefit
In order to be eligible for services under the proposed waiver, youth must:

- Be age 18 through 20 years.
- Receive children's mental health services with SED diagnosis immediately prior to enrollment in the waiver and no longer eligible for those services due to age.
- Be ineligible for the state's Mental Health Services Plan for adults.
- Have incomes equal to or less than 150 percent FPL. There is no asset or resource test.
- Have been recipients of the child welfare foster care system and have been discharged from the child welfare foster care system.
- Be uninsured and ineligible for Medicare or Medicaid.

In addition to the general eligibility criteria, the Department will specifically target SED youth turning 18 who receive residential treatment, therapeutic group care, therapeutic family care, or foster care services, and have no family or other informal support systems on which to rely.

Prior to discharge from the child welfare foster care system, the Child and Family Service social worker and the Children's Mental Health case manager will meet with the individual to develop a transition plan and timeline. Part of that transition plan will include an assessment of eligibility for this waiver. If the individual is deemed clinically eligible and desires to be enrolled in the waiver, the individual will complete an application that will be processed by the county Office of Public Assistance.

Eligibility will be for one year and will be redetermined annually based on diagnosis and other criteria. In the event the individual opts not to participate in the waiver at the time of discharge from the child welfare foster care system and then subsequently would like to participate in the waiver, he or she will be allowed to enroll as long as the eligibility requirements are met and the program is open for new enrollees.

Under the Foster Care Independence Act, the state has the option of providing Medicaid coverage to all young people who were in the foster care system up to age 21. The state has the flexibility to provide Medicaid to reasonable categories of recipients. Therefore, this population is deemed an Optional Population (information provided in a December 1, 2000 letter from CMS to State Child Welfare and State Medicaid Directors).

Physical Health Care Benefit for SED Youths
The DPHHS proposal provides each youth served under this component of the waiver with a comprehensive Medicaid-funded physical health care benefit identical to the benefit available to children enrolled with Montana's Children's Health Insurance Plan (CHIP)—see the description of the CHIP benefit above. The projected cost of providing the CHIP benefit to 300 SED youths is approximately $600,000 per year.

Transitional Mental Health Services Benefit for SED Youths
In addition to the CHIP benefit, the waiver proposal creates a new transitional mental health service benefit specifically designed for SED youths leaving the Children's Mental Health System to adjust to life in the community and make a successful transition to adulthood. Many SED youth are eligible for services under the Chafee Foster Care Independence Act of 1999, which requires that states provide all foster care youth who are likely to age out of care with appropriate services to give them the skills and knowledge they need to make a successful transition to self-sufficiency. In Montana, foster care youth ages 16 to 18 years must be referred to the Montana Foster Care Independence Program to prepare them for adult community living. The program provides tangible life skills instruction such as money management, apartment hunting, employment skills, and prevention resources. The program provides the education and services necessary to obtain and retain employment and housing, and to enter post secondary education and training institutions. Once they age out of care, youth ages 18 to 21 are eligible to continue to receive services, including financial assistance and other assistance necessary to complement their own efforts to achieve self-sufficiency.

Research shows that 38 percent of foster care children are emotionally disturbed and these young people have difficulty acquiring the intangible life skills that most children learn throughout their childhood. Intangible life skills include decision-making, problem solving, impulse control, and basic interactive social skills. Without these skills, they have difficulty learning the tangible life skills taught in an independent living program. As a result, foster care alumni have a greater likelihood than other children to experience unstable living conditions.

Health and medical care represent a challenge for youth aging out of care. Transition from state care generally means that eligibility for Medicaid is lost. The Northwest Foster Care Alumni Study of 2005 found that 54.4 percent of foster care alumni had clinical levels of at least one mental health problem such as depression, social phobia, panic syndrome, or drug dependence. One in five had three or more mental health problems. Emotionally disturbed youth cannot benefit from independent living programs without extra mental and physical health supports. Heath services to give youth greater access to mental health services and to prepare them to manage their own physical and mental health needs are critical to ensuring positive outcomes for foster care alumni.

Enhanced Mental Health Services for SED Youth
To receive supplemental mental health services, the individual must have exhausted outpatient benefits under the CHIP-like benefit and have received prior authorization for these additional benefits.

- Medication management and consultation
- Individual and group psychotherapy

Waiver participants will receive supplemental mental health services from the same providers they use in the CHIP network. These providers will be reimbursed on a fee-for-service basis using the Medicaid fee schedule.

In addition, these waiver participants will receive the following mental health services:

- Community-based mentor relationship.
- Community-based plan to assess needs and skill development plan, goals, objectives, responsibilities, timelines, outcomes, and performance measures.
- Training and instruction to develop intangible life skills, defined as problem solving, decision-making, impulse control, and critical thinking. These skills are needed before the individual can fully comprehend and learn tangible life skills.
- Monitoring waiver services (physical health and mental health) and budgets or service limits.
- Collaboration and coordination with other services such as Montana Foster Care Independence Program, affordable housing, and other poverty related programs.
- Training and instruction to develop social interaction skills.

To provide the new mental health services, the State will contract with vendors that will be selected based on their skills and abilities to serve SED youth. Reimbursement of services may

include per member per month capitation, fee-for-service arrangements, bonus payments for achieving outcomes, or a combination of methods.

SED youth will not incur cost sharing for Transitional Mental Health Services and expenditures for Transitional Mental Health Services will be limited to $4,500 per year per individual. The Department's waiver proposal allocates over $1.5 million per year to provide up to 300 SED youth with transitional mental health services.

Montana recognizes there may be a concern related to coordinating Medicaid and other federal programs. DPHHS will coordinate and ensure that Medicaid is not paying for services typically payable under the Foster Care System and/or Montana Foster Care Independence Program (MFCIP). MFCIP is designed to assist individuals to develop tangible life skills. Tangible life skills include health promotion and preventative services, budgeting and financial management, shopping and work skills to remain in the community, sex offender treatment, and knowledge of community support. In addition to these services, the individuals are eligible for certain stipends and financial assistance to help with secondary education, housing and household goods, travel assistance, and job readiness. This program is funded by the Chaffee grant and is not subject to this waiver, however, the program does provide necessary services to assist the individuals to successfully transition to adulthood.

4. Mental Health Services Plan—Public and Private Health Care Coverage for Low Income Adults with Severe and Disabling Mental Illness

MHSP provides state-funded mental health services for low-income adults who have a Severe Disabling Mental Illness (SDMI) but are not eligible for Medicaid. MHSP services include a limited pharmacy benefit and an array of basic mental health therapy and support services delivered through one of four contracted Community Mental Health Centers. On average, 2,200 adults receive MHSP services each month. Approximately one-third of the MHSP beneficiaries are enrolled in Medicare or have other health insurance coverage, and the remaining two-thirds are uninsured. MHSP is a discretionary program that is not required by state or federal law. As a result, people eligible for MHSP do not have legal entitlement to services. The Addictive and Mental Disorders Division (AMDD) of DPHHS administers MHSP within the funding levels appropriated by the legislature.

MHSP Clinical and Therapeutic Services
MHSP is administered by four Community Mental Health Centers under contract with AMDD. Each mental health center provides services in a multi-county area of the State. Medically necessary services include medication management by medical practitioners and related laboratory services, outpatient individual and group therapies provided by psychologists, licensed social workers or licensed professional counselors, rehabilitation services such as assertive community treatment, psychiatric rehabilitation, and therapeutic support services. As appropriate, individuals may receive additional support services for coordination of benefits, treatment planning, linkage, and referral.

MHSP Pharmacy Services
MHSP includes a limited pharmacy benefit that covers medically necessary psychotropic medications prescribed for the treatment of symptoms of covered diagnoses. The pharmacy benefit is limited to $425 per person per month. MHSP beneficiaries who require medications exceeding the monthly limit are responsible for the costs. MHSP requires copayments of $17.00 per prescription for brand name drugs and $12.00 for generic drugs. AMDD allocates $75,000 per year to the Community Mental Health Centers for assistance to MHSP beneficiaries unable to pay the costs of medications that exceed the monthly cap. MHSP reimburses pharmacies at the current Medicaid reimbursement rate.

MHSP Eligibility
To be eligible for MHSP, an individual must meet clinical, financial, and age criteria established by the Department.

1. The individual must have a Severe Disabling Mental Illness, as determined by a licensed mental health professional through an assessment of diagnosis, functional impairment, and duration of illness.

2. The individual must have a family income equal to or less than 150 percent of the Federal Poverty Level. Determination of financial eligibility is made by staff members of the Community Mental Health Centers and does not include an asset or resource test.

3. The individual must be ineligible for Medicaid as determined by the Department's Public Assistance Bureau.

4. The individual must be at least 18 years of age.

MHSP eligibility is determined at a Community Mental Health Center. A staff member determines if the applicant is financially eligible for the program. Financially eligible applicants undergo a clinical assessment to determine if he or she meets the criteria of having a Severe Disabling Mental Illness.

Reimbursement to the Community Mental Health Centers uses a capitated formula based on individuals enrolled and receiving services. The proposal allocates almost $1.3 million per year in additional Medicaid funding with which to provide existing MHSP services to individuals enrolled under the waiver.

MHSP Proposed Physical Health Benefit
Montana's proposal requests approval from CMS to obtain Medicaid financing for a portion of the state-funded Mental Health Services Plan (MHSP). In addition to the existing MHSP mental health services and prescription drug benefit, the waiver will provide MHSP participants who do not have health insurance with the opportunity to choose among three limited physical health care benefit options.

The three MHSP physical health care benefit options include:

A. *Employer premium assistance*

Uninsured MHSP participants whose employers offer group health insurance can choose to receive assistance with the cost of the monthly premiums for the employer based group insurance. The level of premium assistance available may vary by the age of the individual, but the average amount will not exceed $166.00 per month or $2,000 per year.

Under the waiver, MHSP beneficiaries may choose to purchase individual insurance or group insurance from their employers. While DPHHS wants to permit beneficiaries to purchase health insurance that best meets their needs, DPHHS recognizes the need to establish a minimum level of benefits. A summary of benefits that outlines minimum benefits is on the following page. It is important to note that health insurance purchased by a MHSP beneficiary may vary from these benefits, but the overall benefits must exceed or be equivalent to these benefits.

B. *Individual private health insurance plans*

If employer-based insurance is unavailable or the individual chooses not to participate, he or she will have the option to apply for and enroll in an individual private health insurance policy. The cost of monthly premiums for the individual health care policy selected by a MHSP beneficiary will be paid by Medicaid as long as the cost is not more than a maximum upper limit established by DPHHS. The monthly premium upper limit will vary based on the age of the insured individual, but the average of all payments will be no greater than $166.00 per month or $2,000 per year (see rate chart in Attachment E). DPHHS will encourage private insurance carriers to develop new physical health care insurance options designed specifically to provide coverage to MHSP beneficiaries. Minimum benefits are the same as outlined on the following page.

C. *Medicaid individual health care benefit*

A MHSP beneficiary may choose the option to receive a Medicaid waiver physical health care benefit of up to $2,000 per person per year. A Medicaid waiver Individual Health Care Benefit will be established for each eligible person selecting this option. The benefit may be used to reimburse up to $166.00 per month in Medicaid waiver funded health care services at the Medicaid fee-for-service rate as long as the individual continues to meet the Medicaid waiver program eligibility criteria. If an individual receives less than $166.00 in Medicaid waiver reimbursed services in any month, the difference between the $166.00 maximum and the actual reimbursement will be added to the following month's benefit. The benefit balance can accumulate as long as the individual continues to be enrolled in MHSP, unless the waiver is modified or terminated.

The Individual Health Care Benefit provides access to a range of medical care and services while reinforcing people who are judicious consumers of health care. If the individual withdraws from the program or loses eligibility, any remaining balance of the benefit reverts to DPHHS. DPHHS is exploring the technological and administrative options and issues associated with operating a system of individual health care benefits, including the potential to provide the benefits through a form of debit card. While DPHHS would prefer to implement the health care benefit as part of the existing

Medicaid fee-for-service system, if that is not feasible because of cost, administrative complexities, or unforeseen problems, other administrative options that do not employ Medicaid fee-for-service processes and rates will be explored.

MHSP Physical Health Benefit: Minimum Benefits, Maximum Copayments

Covered Services	Copayments	Limitations/Additional Information
Physician visits	$20 per visit	Six office visits per benefit period
Walk-in clinics, urgent care	$40 per visit	Applies to the six office visit limit
Inpatient hospital	$500 per benefit period	
Outpatient hospital	None	$1,000 maximum per benefit period
Professional provider visits while in hospital	None	
Emergency room	$75 per visit	Does not accumulate to the $1,000 outpatient hospital maximum
Hospice care	None	
Mammograms	None	Lesser of $70 or actual charge
Medical supplies and devices	None	
Deductible	None	No deductible, copayments apply
Maximum benefits	$10,000 per benefit period	All expenditures count toward this maximum except pharmacy benefits
Prescription drugs	$20 generic $30 brand name formulary $45 brand name non-formulary	$200 limit per benefit year

DPHHS estimates that up to 1,500 MHSP clients will be eligible to participate in the new physical health care benefit. Approximately one-third of current MHSP clients will not participate in the proposed waiver program because they currently have private health insurance or they have health care coverage under Medicare. Under the Federal waiver guidelines, the state cannot obtain federal matching dollars for health care services these MHSP clients now receive. Therefore, the state will continue to provide existing MHSP services to MHSP clients who have other coverage using state dollars.

In order to facilitate the most appropriate choice, DPHHS, in cooperation with the four Community Mental Health Centers, will provide education and assistance to MHSP beneficiaries in selecting their health care benefits. While the current plan calls for providing every uninsured MHSP participant with a physical health care benefit, the waiver includes a provision that allows DPHHS to limit enrollment in the physical health care benefit if necessary to ensure the continued budget neutrality or fiscal viability of the waiver. The implementation of a cap on enrollment in the Medicaid physical health care benefit program would not impact the ability of eligible individuals to receive the existing state-funded MHSP pharmacy and therapy benefits. The total cost of the physical health care benefit for MHSP participants is projected to be approximately $3 million per year.

DPHHS will establish a maximum number of individuals to be enrolled in MHSP and anticipates the possibility of a waiting list for services. To improve access, DPHHS may disenroll eligible MHSP beneficiaries who have not accessed treatment for 90 days, in order to reduce the waiting list for those needing services.

Because approximately one-third of MHSP beneficiaries have some health care coverage, they are ineligible for Medicaid funded health care services provided through the waiver. In order to ensure they continue to receive MHSP pharmacy and therapy services, DPHHS will reserve approximately one-third of the current MHSP annual appropriation to continue services for MHSP beneficiaries who have health care coverage. The remainder of the appropriation will be used as matching funds under the waiver. None of the Community Mental Health Services Block Grant will be used for matching funds under the waiver.

New MHSP short term inpatient acute psychiatric services
The waiver provides a total of $200,000 per year in total Medicaid funding for the purchase of short-term, acute inpatient psychiatric care. Clinical review and management of this benefit will be included in the DPHHS utilization review contract, currently held by First Health Services. DPHHS anticipates that community hospitals with psychiatric inpatient units in Glendive, Billings, Missoula, Great Falls, and Kalispell will comprise the provider network for this benefit. Reimbursement will be calculated using the Medicaid fee schedule for DRGs. Because the budgetary allocation for the inpatient benefit is limited, DPHHS may determine it necessary to restrict individual access to not more than one admission per person per year, or to a limited number of days. Because this benefit has not been included in the MHSP plan of benefits since 1999, the demand for inpatient care is difficult to project.

Service Area Authorities
An additional benefit of securing Medicaid funding for MHSP is the ability to reallocate a portion of the federal Community Mental Health Services Block Grant, currently used to fund MHSP services, to address other unmet needs in Montana's community mental health service system. The waiver allocates $240,000 per year of the Community Mental Health Services Block Grant funds to the state's Service Area Authorities (SAA) to address other system of care issues. Montana's three SAAs are stakeholder-based entities that are statutorily mandated to collaborate with DPHHS in the planning and oversight of mental health services. The additional funding will be made available for community-based services for adults who have been identified by the SAAs with Severe and Disabling Mental Illness not available in the existing mental health system.

5. Montana Comprehensive Health Association Premium Assistance Program—Private Health Insurance Coverage for Low-Income High-Risk Uninsured Adults

DPHHS collaborated with the State Auditor's Office and the Montana Comprehensive Health Association (MCHA) board of directors to include a provision in the waiver that will provide Medicaid funding for a portion of the existing state-funded MCHA Premium Assistance Program. MCHA Premium Assistance is a source of health insurance for people who have serious medical conditions that cause them to be denied coverage by private health insurers and whose incomes are less than or equal to 150 percent FPL. The savings realized from the Medicaid financing of MCHA will be reinvested in the MCHA Premium Assistance Program to maintain the long-term viability of the program, maintain or increase program participation, and maintain or increase the level of premium assistance to individual MCHA participants. DPHHS

estimates up to 260 MCHA clients will be eligible to participate in this waiver proposal. Approximately ten percent of the MCHA clients will not be able to participate because they have health care coverage under Medicare. Therefore, the State will continue to provide existing benefits to this group using state dollars.

MCHA History
In 1985, the Montana Legislature created the Montana Comprehensive Health Association (MCHA) to establish a program through which health insurance could be made available to Montana residents who are otherwise considered uninsurable due to medical conditions. MCHA serves those Montanans who are not part of the traditional health insurance market because of a preexisting health condition or a significant exclusion of coverage. MCHA provides "coverage of last resort" and is not intended to duplicate coverage from another source, public or private. MCHA is a private entity, governed by a board of directors made up of five representatives of health insurance carriers doing a high volume of business in Montana, two members at large, and a public interest member. Coverage under MCHA is administered by Blue Cross Blue Shield of Montana. The first MCHA policies, referred to as the Traditional Plan, were issued in 1987. In 1997, in response to new federal legislation, the Montana Legislature added the MCHA Portability Plan for individuals who lose employer coverage. Both plans offer consumers the choice of two options that require different deductibles, copayments, and out-of-pocket maximums.

MCHA Premium Assistance Pilot Program
In September 2002, MCHA implemented a pilot program providing subsidized premium assistance for persons who qualify for the MCHA Traditional Plan and have family income equal to or less than 150 percent of the Federal Poverty Level. The pilot program provides the same benefits as the MCHA Traditional Plan, Option A. The premium subsidy is 65 percent of premium during the preexisting condition waiting period and 55 percent after the waiting period is fulfilled. The premium assistance program has a lifetime coverage maximum of $1,000,000. As of June 2005, 200 people were insured through the premium assistance pilot program.

MCHA Funding
MCHA has four sources of revenue from which to pay claims and administer the program:

1. An annual one percent assessment on the total amount of all premiums paid to each of the health insurance carriers doing business in Montana by the people they insure—currently about $5 million per year;

2. The monthly premiums paid to MCHA for health care coverage by insured participants;

3. A federal grant used to fund premium assistance provided through the MCHA pilot program; and

4. State Special Revenue from tobacco settlement proceeds.

MCHA Benefits and Cost Sharing
The Montana Comprehensive Health Association Premium Assistance Program (Traditional Plan, Option A) has a $1,000 deductible and $5,000 out-of-pocket annual limit. Cost-sharing is 80/20 coinsurance.

Covered Services	Limitations/Additional Information
Inpatient hospital care	
Outpatient hospital care	
Home health care	180 visits per year
Professional services	
Prosthetics	
Durable medical equipment	$5,000 annual maximum
Immunizations	
Services for severe mental illness	
Rehabilitation therapy	
Office visits	
Well-child care	Up to 24 months of age
Laboratory and X-ray	
Prescription drugs	
Ambulance	
Radiation and chemotherapy	
Maternity screening and services	
Mammography	
Diabetes education	
Surgery and anesthesia	
Newborn and adopted child care	31 days
Convalescent home care	60 days
Transplants	$150,000 maximum

6. New Limited Health Care Benefit—Public and Private Health Care Coverage for Uninsured Working Parents of Children with Medicaid

Parents of children with Medicaid risk losing their own Medicaid eligibility when they become employed and their incomes exceed the eligibility standard for adults in the Family Medicaid eligibility category. In many cases, the ineligible parents are working in low-wage jobs where they make too much money to be eligible for Medicaid for themselves, but their incomes are low enough to allow their children to remain Medicaid-eligible due to the higher family income standards for children. To address the obvious disincentive to continued employment that comes with the loss of Medicaid funded health care, the federal government permits states to maintain the Medicaid eligibility of adults who are making the transition from Family Medicaid to employment. Montana currently provides two six-month periods of Transitional Medicaid to families whose incomes exceed the Section 1931 Medicaid eligibility standard.

Medicaid Funded Benefit for Working Parents
The DPHHS waiver proposal includes a provision for Medicaid-funded physical health care for up to 600 working parents of Medicaid-eligible children per year, at a projected annual cost of about $1.3 million. This population is considered an Optional Population. Medicaid parents will be able to choose one of the same three physical health options available to the MHSP participants, described above.

- Employer premium assistance
- Individual private health insurance plans
- Medicaid individual health care benefit

Eligibility
In order to qualify for Medicaid-funded benefits, an individual must:
- Be employed
- Have an income equal to or less than 200 percent FPL
- Be a Montana resident
- Have at least one child in his or her care under the age of 21 who qualifies for Medicaid

Monitoring Plan
DPHHS will assess the impact that extending publicly funded health care has on the ability of working parents to get and keep jobs, secure private health insurance for themselves and their families, and ensure their children are as healthy as possible. The Department intends to measure the impact of the policy change by gathering evaluative data such as the percent of people who stay employed, the length of their employment, the number who enroll in private health insurance, as well as the impact of the utilization of preventive health care services by, and the health status of, their children. Because people in this waiver eligibility group must be working in order to qualify, and because one of the primary goals of the extended coverage is to assist them in accessing private insurance, the parents of Medicaid children are a logical group to give the option to choose between either employer insurance premium assistance, private insurance, or direct public benefits from the Department.

7. New Limited Health Care Benefit—Private Health Insurance Premium Assistance (Employee) and Premium Incentive (Employer) for Uninsured Working Parents and Uninsured Working Youth Ages 18 through 20

Many parents working for small business employers do not qualify for Medicaid because their incomes or resources exceed the eligibility standards for adults in the Family Medicaid eligibility category. In many cases, the ineligible parents are working in low-wage jobs where they make too much money to be eligible for Medicaid. In addition, many working parents are employed with small businesses that often do not provide health insurance coverage for their employees. Many working Montanans find themselves uninsured because their employer does not offer group insurance or the group insurance is too expensive, as are most of the available private health insurance policies for individuals. If a need for medical care arises for the employee or his or her children, the need may go unmet. Lack of timely and appropriate medical care often leads

to more serious health problems, which in turn lead to voluntary or involuntary loss of employment and the possibility of a parent's eventual eligibility for Medicaid.

Eligibility
Employees who meet the following criteria

- Group One
  - Uninsured adults ages 19 through 64 with children under age 21
  - Incomes less than or equal 200 percent FPL
  - Not eligible for Medicaid

- Group Two
  - Uninsured youth ages 18 through 20
  - Incomes less than or equal to 200 percent FPL
  - Not eligible for Medicaid or CHIP

This alternative approach to serving low-income parents with children under a waiver is possible because the state already has the option to raise the income eligibility standards for its traditional Medicaid program in order to serve this population with higher incomes, although for reasons related to fiscal concerns of creating an expanded Medicaid entitlement, the State has not done so. The individuals in this eligibility group are considered an Optional Population under HIFA. Waiver services will not be available to childless adults.

Services
The waiver will provide Medicaid funded premium assistance payments for the employee and premium incentive payments for the employer, for up to 1,200 youth and working parents with children per year at a projected annual cost of approximately $3.3 million. The actual amount of premium incentive and assistance payments may vary. The purchasing pool board of directors will set the level of incentive payments, which must be the same for each participating employer. The board will also set the amount of premium assistance payment.

Monitoring Plan
DPHHS is interested in assessing the impact that extending publicly funded health care would have on the ability of working parents to get and keep jobs, secure private health insurance for themselves and their families, and ensure their children are as healthy as possible. The Department will measure the impact of the policy change by gathering evaluative data such as the percent of people who stay employed, the length of their employment, as well as the impact of the utilization of preventive health care services by, and the health status of, the employee and his or her children.

Nurse First Advice Line
The Department proposes offering a value-added service to all beneficiaries served by the HIFA waiver. The service is a 24-hour, 7-day a week, toll-free nurse advice line staffed by licensed, registered nurses. Beneficiaries are encouraged to call the nurse line any time they are sick, hurt, or have a health concern. The nurses ask questions about the callers' symptoms using clinically

based algorithms, then direct them to seek the appropriate level of services at the appropriate time. Levels of care recommended range from emergency room to self-care at home. The nurses do not diagnose or provide treatment. The program is voluntary though participation is strongly encouraged.

The Nurse First Advice Line is expected to lower costs both through direction to lower levels of care where appropriate (self-care instead of doctor visit) and through direction to higher levels of care where appropriate, which can prevent costly hospital stays and extended illnesses. The Department believes this value-added service will work in conjunction with other providers and will assist beneficiaries to more efficiently utilize their health care benefits.

ATTACHMENT E: COST SHARING LIMITS

1. Basic Medicaid Existing 1115 Waiver

Individuals subject to the demonstration who are tribal members are not charged cost sharing when receiving services from the Indian Health Services.

The amount of cost sharing for individuals in the demonstration is the same as the amount specified in the State Plan for Montana. Affected providers or services exempt from cost sharing include: emergency services, hospice, non-emergency transportation, independent laboratory and x-ray services, and family planning.

Cost Sharing			
Enrollment Fee	**Copayments**	**Coinsurance**	**Maximum**
None	$1-$5 prescription $1-$5 outpatient office visit	$100 inpatient hospital stay	$25 monthly prescription maximum

2. Mental Health Services Plan

A. Mental Health Benefit

Beneficiaries have no cost sharing for medically necessary services including medication management by medical practitioners, and related laboratory services, outpatient individual and group therapies provided by psychologists, licensed social workers or licensed professional counselors, rehabilitation services such as assertive community treatment, psychiatric rehabilitation, and therapeutic support services. As appropriate, individuals may receive additional support services for coordination of benefits, treatment planning, linkage, and referral, also with no cost sharing required.

MHSP includes a limited pharmacy benefit that covers medically necessary psychotropic medications prescribed for the treatment of symptoms of covered diagnoses. MHSP requires copayments of $17.00 per prescription for non-preferred drugs and $12.00 for preferred drugs. The pharmacy benefit is limited to $425 per person per month. MHSP beneficiaries who require medications exceeding the monthly limit are responsible for the costs.

Using an analysis of a recent four-month period, the average monthly copayment for each MHSP enrollee was $55.29. One-hundred enrollees needed drugs in addition to the $425 and their average additional costs were $165.76 per month.

B. Physical Health Benefit

MHSP beneficiaries will have the opportunity to choose between a Medicaid-funded fee-for-service benefit of $166.00 per month, or premium assistance for a group or individual plan of the same amount. Beneficiaries who choose one of the premium assistance options will be subject to cost-sharing rules of the insurance plan in which they enroll.

The rate chart below was calculated based on current age distribution (average age 40) and premium ratio for the largest health insurer in Montana.

Age	Monthly Premium Equivalent
Under 20 years	$101.00
20 to 24 years	$116.00
25 to 29 years	$130.00
20 to 34 years	$138.00
35 to 39 years	$151.00
40 to 44 years	$170.00
45 to 49 years	$198.00
50 to 54 years	$225.00
55 to 59 years	$263.00
60 to 64 years	$313.00
Average amount	$166.00

MHSP beneficiaries who choose the fee-for-service benefit will have the same copayments as people with State Plan Medicaid when they use their benefit.

3. Uninsured working parents of children with Medicaid
Uninsured working parents who have children with Medicaid will have the opportunity to choose between a Medicaid-funded fee-for-service benefit of $166.00 per month, or premium assistance for a group or individual plan of the same amount. People who choose one of the premium assistance options will be subject to cost-sharing rules of the insurance plan in which they enroll.

People in this eligibility group who choose the fee-for-service benefit will have the same copayments as people with State Plan Medicaid when they use their benefits.

4. Uninsured children
Uninsured children will receive the same benefit as children enrolled in CHIP, with the same cost-sharing requirements. There are no premiums, no deductibles, and no coinsurance. Copayments are:

- $3 physician visit
- $25 inpatient hospital visit
- $5 outpatient hospital visit
- $5 emergency room visit
- $3 generic prescription drug
- $5 brand name prescription drug

There are no copayments for dental visits or well-child or well-baby care.

5. Uninsured former SED foster youth ages 18 through 20
Uninsured former SED foster youth ages 18 through 20 will receive the same benefit as children enrolled in CHIP, with the same cost-sharing requirements. There are no premiums, no deductibles, and no coinsurance. Copayments are:

- $3 physician visit
- $25 inpatient hospital visit
- $5 outpatient hospital visit
- $5 emergency room visit
- $3 generic prescription drug
- $5 brand name prescription drug

There are no copayments for dental visits or well-baby care. There is no cost-sharing for enhanced, transitional mental health services or tangible life skills instruction.

6. Montana Comprehensive Health Association
The Montana Comprehensive Health Association members are subject to $1,000 annual deductibles and $5,000 out-of-pocket annual limit. After the annual deductible is met, cost-sharing is 80/20 coinsurance.

7. Uninsured working adults 19 to 65 with children under age 21 and uninsured working youth ages 18 through 20

Cost sharing for this waiver group will vary. Participants will receive assistance paying monthly insurance premiums but may have additional costs in the form of deductibles, copayments, and/or coinsurance.

Premium assistance for all applicable programs under the waiver
Cost-sharing for all premium assistance programs may require additional premium cost, deductibles, copayments, and coinsurance for adults who participate in employer sponsored programs, individual insurance plans, or the Montana Comprehensive Health Association. Cost-sharing for these adults may exceed maximum cost-sharing allowed under the Medicaid State Plan.

Montanans who will be served under the waiver are currently responsible for 100 percent of the costs of their health care. This waiver will reduce their out-of-pocket costs and give them greater access to health care.

ATTACHMENT F: ADDITIONAL DETAIL REGARDING MEASURING PROGRESS TOWARD REDUCING THE RATE OF UNINSURANCE

1. 2003 Montana Household Survey

Prior to the receipt of the State Health Planning Grant, Montana relied on data through federal or private efforts to describe its uninsured population. In July of 2002, the Montana Department of Public Health and Human Services was awarded a planning grant from the Health Resources and Services Administration (HRSA) in order to conduct an in-depth analysis of Montana's uninsured population, obtain Montana specific data about the uninsured and develop a six-year strategic plan to provide the uninsured access to affordable health insurance coverage. This report presents the results of the project.

Governor Judy Martz appointed a twenty member State Health Planning Grant Steering Committee to guide the project development and implementation. Representatives included individuals from across the state representing a cross section of key public and private stakeholders, including business and industry, minority populations, nonprofit groups, health care delivery professionals, the health insurance sector, state agencies and consumers. In addition, three work teams assisted the Department of Public Health and Human Services, the Grant Director, and the researchers in various aspects of the grant projects. Work teams supporting the project included the Data Team, the Safety Net Team, and the Coverage Options Team.

The Montana Department of Public Health and Human Services contracted with the University of Montana's Bureau of Business and Economic Research to conduct two surveys: the Montana Household Survey and the Montana Employer Survey. These surveys were developed in consultation with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota and with the assistance of the Data Team. The University of Montana also completed six focus groups and 30 key informant interviews.

The Department's final report to HRSA, including detailed information on survey methods and development of statistical weights, can be found at www.dphhs.mt.gov/uninsured/pdffiles/mtfinal102004.pdf

The 2003 Montana Household Survey was a stratified random digit dial telephone survey. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic Research, from December 2002 to May 2003. One person in each household was randomly selected as a target for the survey; if this person was a child, then an adult was asked to respond on behalf of the child. In order to fulfill the study goals of getting better information on health insurance disparities by race/ethnicity and region, some geographic areas of the state were sampled with higher probability than other areas. In analyzing the data, statistical weights are used in order to generalize the results to the entire population of the state. A total of 5,074 interviews were completed. The overall response rate to the 2003 Household Survey was 75 percent. The sample size includes all age groups and is much larger than other

samples used for estimating the state's uninsured rate such as the Census Population survey (approximately 1,500 households) or the Behavioral Risk Factor Survey (3,100 Montana adults) conducted by the Centers for Disease Control.

The final Montana Household Survey will be conducted by the Bureau of Business and Economic Research during 2006. Grant funding from HRSA will then end.

SHADAC is assisting the Department in developing surveys to replace the Montana Household Survey and ensuring the data will be statistically comparable. Questions on the Behavioral Risk Factor Surveillance System (BRFSS) annual survey will elicit health care coverage rates for Montanans.

2. Monitoring programs
Montana will monitor how the waiver programs affect the following areas:

a. Level of uninsurance: The progress achieved each year of the demonstration in reducing the number of uninsured residents. The state will use updates of the state survey to track its progress, building on the baseline data gathered in the 2003 survey.

b. Other factors impacting the uninsured rate: The factors potentially affecting the number of uninsured people in the state, including employment levels, fluctuations in the economy, health insurance premium costs, and changes in federal or state legislation or policy.

c. Trends and changes in the sources of health insurance coverage for the state's population: Using the 2003 Montana Household Survey for each category, Montana will track changes in the source of health care coverage of Montanans.

d. Impact on small employers: The progress made in increasing the number of small employers that did not previously offer a health coverage benefit.

e. Access to care: The number of individuals receiving health benefits through the waiver who report (on survey) that they have improved access to health care.

f. Budget neutrality: The annual "draw down" on the savings previously achieved under the Basic 1115 Medicaid Waiver for Able-Bodied Adults.

The Department will also monitor the impact of the waiver on employer contribution levels for group health insurance plans.

3. Reporting
Montana will summarize the results of its monitoring and evaluation efforts six months after the end of each demonstration year. Interim, quarterly reports will include basic enrollment and demographic data on the populations receiving services under the waiver.

4. Evaluating

SHADAC is assisting the Department in developing a method to measure the effectiveness of programs being implemented as a result of work done through the State Health Planning Grant. Montana plans to follow the guidelines for evaluating demonstrations set forth by the CMS Division of Quality, Evaluation, and Health Outcomes. The state will fully cooperate with independent evaluations of the programs arranged by CMS.

ATTACHMENT G: BUDGET WORKSHEETS

If Montana's waiver proposal is approved by CMS, DPHHS estimates the waiver will generate approximately $15 million dollars in additional federal Medicaid revenue per year with which to provide needed health care benefits to several thousand uninsured Montanans. It would do so without the need for additional state dollars above the amount already appropriated for the Mental Health Services Plan, the Montana Comprehensive Health Association, and the existing 1115 waiver.

Existing Section 1115 Waiver Population
Members eligible for Medicaid under Sections 1925 and 1931 of the Social Security Act and enrolled in the existing 1115 Basic Medicaid Waiver for Able-Bodied Adults make up one Medicaid Eligibility Group (MEG). Consistent with the budget neutrality requirement, the total Medicaid expenditure for services to the Expansion Populations, MHSP and MCHA, must be absorbed within the average PMPM expenditure cap of the Basic Medicaid MEG that is receiving a reduced package of Medicaid benefits.

Actual expenditures for this population:

HISTORIC DATA: BASE YEAR (BY) AND 4 PRIOR YEARS FOR MANDATORY POPULATIONS

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	1998	1999	2000	2001	2002	5-YEARS
TOTAL EXPENDITURES					Base Year	
Pop. 1	14,918,182	14,501,766	15,855,385	$23,397,273	26,222,819	$94,895,425
ELIGIBLE MEMBER MONTHS	111,274	99,572	92,936	110,541	121,668	
COST PER ELIGIBLE	134.067096	$ 145.64	$ 170.61	$ 211.66	215.527657	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		-0.02791332	0.09334167	0.475667289	0.1207639	15.14%
ELIGIBLE MEMBER MONTHS		-10.52%	-6.66%	18.94%	10.07%	2.26%
COST PER ELIGIBLE		8.63%	17.14%	24.06%	1.83%	12.60%

Total savings from existing waiver

	Five year total	1998 estimate	1999	2000	2001	Base year 2002
Net payment	$16,346,102	$2,659,234	$2,624,675	$2,944,603	$3,624,988	$4,492,602
Member months		111,274	99,572	92,936	110,541	121,668
PMPM		$23.90	$23.36	$31.68	$32.79	$36.93

Optional Waiver Populations

The following four optional populations are groups to whom Montana has the option to extend Medicaid eligibility but currently does not. These optional populations meet the waiver cost neutrality test as long as the average expenditure for their services under the waiver is less than or equal to the projected average expenditure had they received full Medicaid benefits.

- Uninsured low income children
- Uninsured former SED children in foster care ages 18 through 20
- Uninsured parents of children with Medicaid
- Uninsured working parents with children; uninsured youth

New Optional Population Projections

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05
Low Income Children							
Eligible Member Months			19,200	19,200	15,000	10,500	6,000
Total Cost per Eligible	3.00%		$134.14	$138.16	$142.31	$146.58	$150.98
Total Expenditure			$2,575,488	2,652,753	2,134,637	1,539,073	905,855
SED Youth							
Eligible Member Months			1,200	2,400	3,600	3,600	3,600
Total Cost per Eligible	4.00%		$554.17	$576.33	$599.39	$623.36	$648.30
Total Expenditure			$665,000	$1,383,200	$2,157,792	$2,244,104	$2,333,868
Parents with Medicaid children							
Eligible Member Months			7,795	7,689	5,767	3,877	2,138
Total Cost per Eligible	4.00%		$166.67	$173.33	$180.27	$187.48	$194.98
Total Expenditure			$1,299,222	$1,332,843	$1,039,649	$726,882	$416,795
LI Parents & Youth 18-21							
Eligible Member Months			27,000	27,363	27,363	27,363	27,363
Total Cost per Eligible	0.00%		$121.38	$121.38	$121.38	$121.38	$121.38
Total Expenditure			$3,321,419	$3,321,419	$3,321,419	$3,321,419	$3,321,419

Low income children total with waiver $9,807,805
SED youth total with waiver $8,783,964
Parents with Medicaid children total with waiver $4,815,391
Low income parents and youth total with waiver $16,607,096

Expansion Waiver Populations
Participants in the Mental Health Services Plan who are uninsured and participants in the Montana Comprehensive Health Association Premium Assistance Program are expansion populations as they are not able to be covered by Medicaid under any situation. The cost of services for Expansion Populations must be offset in one of three ways identified by CMS:

- Offset the additional expenditures with unused federal DSH authority
- Offset the additional expenditures with unused federal SCHIP funds
- Offset the additional expenditures by providing reduced benefits to, or requiring increased cost-sharing of, other Medicaid eligibility groups.

Expansion population projections

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05
MHSP							
Eligible Member Months			17,688	17,688	17,688	17,688	17,688
Total Cost per Eligible	3.92%		$565.47	$587.64	$610.69	$634.67	$659.60
Total Expenditure			$10,002,033	$10,394,113	$10,801,562	$11,224,984	$11,665,003
MCHA							
Eligible Member Months			1,800	1,800	1,800	1,800	1,800
Total Cost per Eligible	14.97%		$320.18	$368.10	$423.23	$486.68	$559.64
Total Expenditure			$576,324	$662,600	$761,791	$875,831	$1,006,943

MHSP total with waiver $54,087,695
MCHA total with waiver $3,883,488

Montana's HIFA waiver proposal includes a provision to achieve budget neutrality by capturing savings that are realized through an existing 1115 demonstration waiver already approved by CMS and currently operating in Montana, thereby offsetting the increased cost of services to the two waiver Expansion Populations.